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APPLICATION FOR AGENCY APPROVAL AS A REHABILITATION FACILITY

Michigan Department of Licensing and Regulatory Affairs
Workers' Compensation Agency
P.O. Box 30016, Lansing, MI 48909

Name of Facility/Company			
Address	City	State	Zip
Phone Number w/Area Code	E-mail Address		
Name of Chief Officer	Title		

Check all that apply: ☐ Public ☐ Private ☐ Profit ☐ Non-profit

☐ Corporation Date of Incorporation: _____ State: _____

☐ Private company/not incorporated

Federal Employer Identification Number (FEIN)	No. of Employees Providing Vocational Rehabilitation Services

1. If currently licensed, certified, approved or accredited by any public or private body, indicate name, address, licensure number if appropriate, and expiration dates. (If more than one certification or accreditation, list them all.)

2. List names/qualifications of professional staff providing vocational rehabilitation services (attach résumés).

3. Complete the **Service and Fee Schedule** section of this application indicating services you provide, units of service, and cost of each designated service.

4. Attach at least 3 letters of recommendation from customers you have served (e.g. Michigan insurance carriers and/or employers, vocational counselors, other agencies or facilities, or individual clients with injuries/disabilities.)

5. State what experience or qualifications you have in workers' compensation rehabilitation.

6. Attach any supportive data, list of activities or other such information that you feel may assist in evaluating your application.

SERVICE AND FEE SCHEDULE

I am/We are qualified to provide the following services for workers' compensation rehabilitation (check each service you are qualified to provide or submit a copy of your company's fee schedule):

	SERVICE	UNIT OF SERVICE	FEE
Vocational Rehabilitation/ Counseling Services:			
a.	Job Analysis		
b.	Job Modification/Ergo Eval		
c.	Analysis of Transferable Skills		
d.	Labor Market Survey		
e.	Vocational Testing		
f.	Work Evaluation		
g.	Work Adjustment		
h.	Job Seeking Skills Training		
i.	Job Development		
j.	Job Placement/RTW Services		
k.	Follow-Up Services		
l.	On-the-Job Training		
m.	Vocational Counseling		
n.	Case Management/Appointments		
o.	General Counseling Services		
p.	Pain Management Counseling		
q.	Education Support		
r.	Other (Specify)		
Medical Case Management			
a.	Case Evaluation		
b.	Case Management		
c.	Physician Appointments		
d.	RTW Services/Job Analysis		
e.	Ergonomic Evaluation		
f.	Client Contact/Meetings		
g.	Utilization Review		
h.	Professional Appointments		
i.	Other (Specify)		

I authorize the Department of Licensing and Regulatory Affairs, Workers' Compensation Agency, to make any investigation of the application and supporting documents. I understand that any omission or misrepresentation may result in rejection or revocation of approval. I hereby agree to be bound by all rules, regulations, policies and procedures as established by the Agency and my professional certifying and licensing bodies. I realize that violations may result in revocation of approval. I also agree to notify the Agency of any violations or possible violations.

Print or Type Name _____ Title _____

Signature _____ Date _____

Subscribed and sworn to before me this

_____ day of _____, 20 _____

Notary Public _____

_____ County, Michigan.

My Commission Expires:_____.

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

Authority: Workers' Disability Compensation Act, 418.319
Completion: Voluntary
Penalty: None

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